Incident Reporting in Medicines Information Scheme (IRMIS)

Q4: October - December 2020

Reports	
Total number enquiry incidents since January 2005: 960 (rolling total for 2020: **55**)	**Total number publications incidents since April 2013: 13**
Enquiries	**Publications/Pro-active work**
Number for this period: 17	Number for this period: 1
Number of errors: 14	Number of errors: 1
Number of near misses: 3	Number of near misses: 0
Number related to data: 8	Number related to data: 1
Number related to advice: 9	Number related to advice: 0
Number where description 'not known': 0	Number where description 'not known': 0

Report Summary

The main theme from enquiry related errors this quarter involved drug calculations (as seen in 2020 Q3). In particular, performing and/or checking calculations whilst the caller is on hold. No incident resulted in patient harm. The most common cause of incident was high workload followed by inadequate research and communication problems. The latter is notable from the number of incidents that related to mishearing the drug name.

There was one incident relating to publications this quarter which occurred due to technical issues when copying from Word document to webpage.

Two reported incidents relate to events that took place prior to 2020 and were detected during the use of past enquiries. Readers are reminded that errors on archived enquiries should be highlighted with a 'note' on the enquiry (in MiDatabank) to avoid re-use of the enquiry, reported via IRMIS and local DATIX (or similar), and removed from MiSharer (if shared). Note that the IRMIS database is only accessible via NHS networks, e.g. via VPN when working from home.

Chart 1 shows a quarterly comparison of potential risk to the patient due to an error or near miss in MI.

Data relating to identified causes and enquiry types for incidents is presented in chart 2 and 3. Table 1 (a-c) summarises the incidents reported and provides suggested actions and/or reminders from the QRMG to aid mitigation of risks at each stage of the enquiry answering process.

Help us improve

The QRMG are keen to get your views on the IRMIS report. Please complete a short survey at https://www.smartsurvey.co.uk/s/D6A8P3/. Alternatively, email us at QRMG.ukmi@nhs.net.

Contact

Author: Iram Husain, QRMG.ukmi@nhs.net
IRMIS database technical queries: pharmacy.support@wales.nhs.uk

Chart 1: Quarterly comparison of potential risk to patients through reported errors or near misses in medicines information (MI) services.

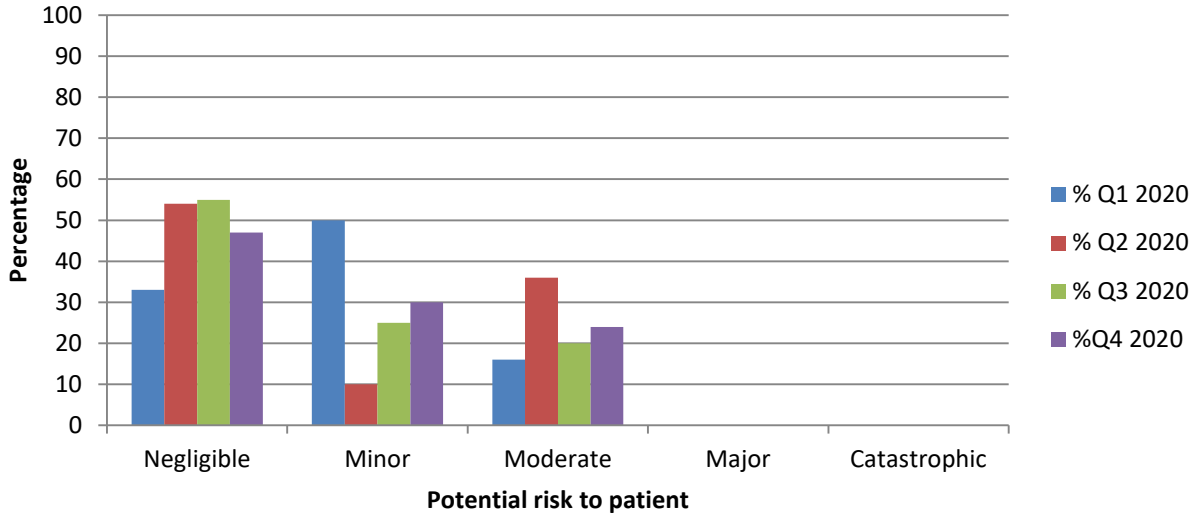


Chart 2: Percentage reported common causes of MI incidents for Q4 2020*

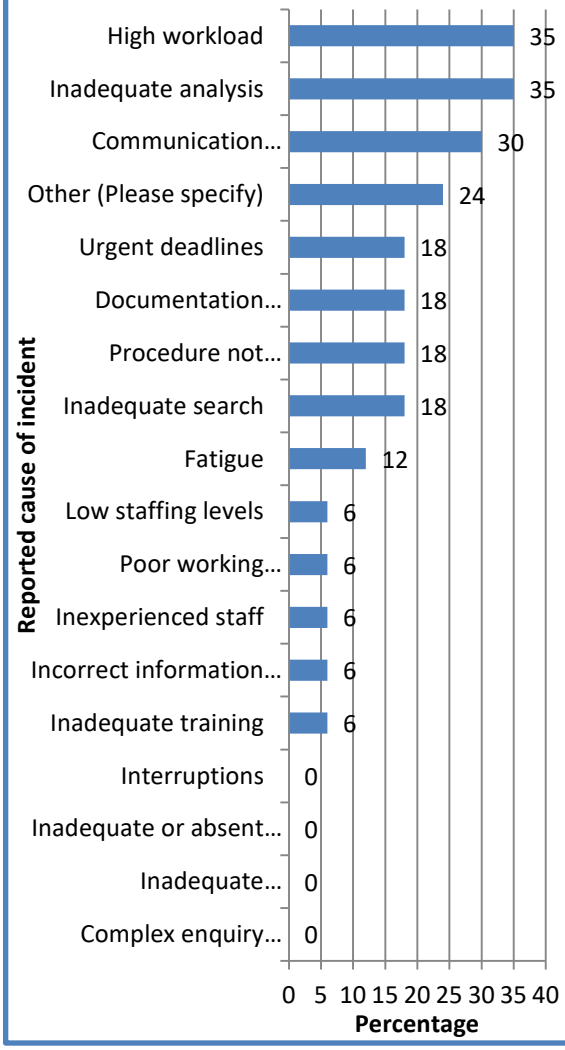
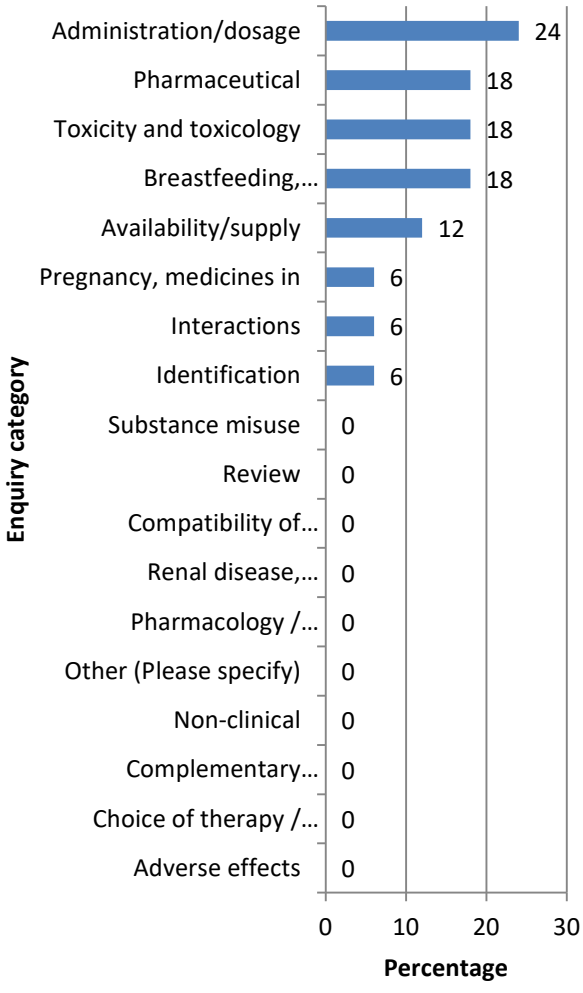


Chart 3: Percentage reported types of enquiry involved in MI incidents for Q4 2020*



*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1166 resulted when the enquiry answering process was completed whilst the enquirer was on hold. The BNF was used to locate product excipient data. Further research was done after the answer had been given and highlighted an error in advice. Confounding this further was the lack of any contact details taken initially.	➢ Do not attempt to answer questions that require the interpretation of a resource whilst the caller is on hold. Especially if a drug calculation is involved. ➢ Always use at least two resources when researching enquiries and ensure they are the latest versions (see UKMi Recommended Resource Lists). ➢ Take the contact details for all enquirers at the beginning of the conversation to allow the service to contact them. This is standard practice for all MI services; see the UKMi MI Enquiry Answering Guidelines (EAG). ➢ Resources appropriate for pharmaceutical excipient enquiries are in the EAG. ➢ For all drugs, it is good practice to obtain the name, dose, frequency, duration and indication to aid in clarity. Where there is doubt, a phonetic alphabet should be used to spell the drug name back to the caller. It may be useful to display a list of commonly confused drug names. ➢ Physical product identification should be done once the product is in MI, photos of the product are available, or a completed TICTAC form (for centres with access) has been received. This will aid more accurate product identification compared to a visual description over the phone. Further guidance can be sought in the EAG section 'Pharmaceutical identification'.
Incident 1168 and 1172 occurred when drug names were misheard as erythromycin instead of azithromycin and methotrexate instead of mesalazine respectively. It is not clear if a phonetic alphabet was used to confirm the drug names.	
Incident 1178 was a calculation error which occurred when answering the question with the caller on hold. The volume calculation for an injection administered via an enteral feeding tube was calculated to be 100 times greater, e.g. 200ml instead of 2ml. The unusually high volume was not noticed when giving the answer. Incident 1189 was also a calculation error whilst the caller was on hold. The wrong Toxbase information was used to calculate paracetamol toxicity (child information instead of adult).	
Incident 1179 related to tablet identification where the name of the enquirer and tablet markings were misheard even though a phonetic alphabet was used. This resulted in the incorrect markings being researched and the email answer being undelivered.	

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1167 used a Toxbase monograph however not all the information in the resource was read in detail and resulted in important information being missed in the answer. Incident 1169 was similar whereby the SPC for Creon (porcine enzymes) was not read in full and advised as suitable for a vegan patient. Incident 1182 also related to use of the eMC where the advanced function provided incomplete results when searching for a lactose free product.	➢ All MI staff should be familiar with how to use/navigate the resources accessed by an MI service. This includes limitations of common MI resources. ➢ Use the most current resource when researching enquiries, see UKMi Recommended Resource Lists. ➢ Carefully read the content of resources used to answer enquiries to avoid missing important/relevant information/data. ➢ Do not copy and paste large amounts of information from resources into MiDatabank. Important information could be missed when re-reading large amounts of text in a hurry. ➢ With regards to allergies and suitable products, it is good practice to advise the caller that they make the dispenser aware of the allergy when the product is collected so that a second check may be performed. ➢ It is good practice to obtain third party verbal information (e.g. manufacturer's information) in writing before incorporating into the answer. This may take extra time. ➢ Always escalate errors in manufacturer's information to the Company in the first instance. ➢ When using MiDatabank keywords, allocate the correct salt for drugs where more than one exists.
Incident 1170 was a result of verbal misinformation from the manufacturer regarding product strength.	
Incident 1181 resulted from researching the wrong salt of hyoscine. The enquiry related to the butylbromide salt (Buscopan) but the research was conducted using the hydrobromide salt. The source of the error was a past enquiry which had confused the two salts.	

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1167 related to the toxicity of an animal's medication in a human. A monograph was available for this exact situation on Toxbase. MI handled the enquiry and made recommendations but forgot to advise the caller to follow the patient up with blood monitoring.	➢ MI staff are clear on when to refer enquirers directly to specialists. MI services should have an SOP or service statement to this effect. ➢ All MI staff should learn how to use Toxbase monographs. Free online learning is available at https://www.toxlearning.co.uk/login/index.php after individual registration. ➢ All adverse reactions to animal medicines including a person's reaction (or lack of) should be reported to the Veterinary Medicines Directorate. ➢ It is good practice to review enquiries for all the issues that are raised and then research and answer those suitable for MI responses. Other issues should be signposted to relevant sources. ➢ Always allow time to re-read the question and final answer to detect any missed issues or additional concerns. ➢ Maintain current awareness of relevant topics. Pharmacy staff should sign up for the NICE Medicines Awareness Daily news and, given the current pandemic, the SPS weekly update. ➢ Refreshers in basic drug principles can be found in MiCAL and MLP Drug Handling. ➢ Pharmacy staff should be competent in drug related calculations. The MLP and MiCAL provide worked examples to aid staff training. ➢ Double checked all calculations before giving the answer. This includes calculations done at any stage of the enquiry. The checker does not have to be MI based staff and documentation of the check should be made. ➢ It is good practice for senior MI staff to retrospectively review all completed answers on a daily basis.
Incident 1183 resulted when the caller wanted confirmation of local practice. This was answered but the patient safety aspect of a PRN dosing of metronidazole suspension as a gargle was not questioned.	
Incident 1176 related to a lack of current awareness regarding flu vaccine products and choices in patients with excipient allergies.	
The answer from incident 1173 increased the risk of toxicity in an infant from an error in calculation but did not change the advice given (referral to A&E). Incident 1174 was also reported as a calculation error when a half-life calculation was not second checked. Incident 1175 used the wrong data to calculate drug clearance (T_{max} instead of half-life). Whilst incident 1177 confused dilutions by a factor of 10 for a question regarding minimum IV volume. No calculation check took place prior to giving the answer out in any of these reports.	

Publication Incidents

One reported publication error (incident 155) related to wrong data due to technical issues when copying data from a Word document to a web page in November 2020. The error carried a potentially 'minor' risk to patients, with a 'possible' likelihood of recurrence. The publication update was issued nationally on the SPS website and sent via a targeted distribution list (audience>500). A reader contacted the author a month later to highlight a numerical error in dosing on the webpage (the full document was attached to the same page and contained no errors):

The Word document read: 2.5g of …. and 3.5g of…

The webpage read: 5g of …. and 5g of…

A technical glitch on the webpage resulted in the volumes being copied without the first digit. The webpage summary had not been second checked though the attached full document had undergone a complete check as per UKMi guidance. The webpage has now been rectified.

QRMG Recommendations:

- Any errors relating to MI material on the SPS pages should be reported to website administrators (via 'Get in Touch' or email LNWH-tr.spsquestions@nhs.net). The author will then be informed by the relevant SPS team to take the necessary actions to correct the error. The author will also complete an IRMIS entry for any MI produced publications.